



Idaho State Board of Pharmacy

3380 Americana Terrace #320 PO Box 83720 Boise, ID 83720-0067
208/ 334-2356 Phone 208/ 334-3536 Fax

REQUIRED DOCUMENTS – MAIL SERVICE PHARMACY

The following documents must be submitted with an application for a mail service pharmacy license:

- \$500 fee (*no fee required for name or address change*)
- A copy of the facility's current pharmacy license for *resident state*
- A list of states your facility is licensed in
- A copy of the facility's current DEA registration
- A copy of the current state license of the pharmacist in charge
- A copy of the current facility inspection report issued by the home state. (*Applications without facility inspection reports will not be processed*)
- Description of pharmacy operation including on-call procedures
- A complete copy of corporate officers or partners
- A completed Patient Communication worksheet (*see reverse of this form*)
 - If listing 'On-Call' hours, include policies and procedures regarding 'On-Call' hours and a description of how patient records are accessed during those hours

Note: The name (or names) and address on the state and federal license/registration copies submitted to support an application must match the name (or names) and address listed on the application

REPORTING REQUIREMENTS

469.01 Prescription Reporting Requirements. All community and mail service pharmacies will report by the first of every month or more often as directed by the Board, certain data, as required by the Board, on all schedule II, III, and IV controlled substance prescriptions filled. The data may be reported in the form of diskette, direct computer link, magnetic tape or other method as approved by the Board.

The Idaho Board of Pharmacy contact regarding the reporting process is Teresa Anderson. She can be reached at 208/334-2356.

Be sure to indicate on the application if you will be shipping controlled substances or if you are requesting an exemption.



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Application for Idaho Registration for Out of State Mail Service Pharmacy

Fee: \$500 – Incomplete applications will be returned unprocessed

Type of Application: (circle) New Ownership Change Name Change (NO FEE) Address Change (NO FEE)

Previous registration #: _____ **Name:** _____

Name of Business: _____

Address: _____ **City:** _____ **State:** _____ **Zip +4:** _____

Pharmacy Phone: _____ **Pharmacy Fax:** _____

Pharmacist In Charge (PIC): _____

Contact Person: _____ **Phone/Email:** _____

Pharmacy Owner: _____

Type of Ownership: (Circle and attach listing of officers, partners, etc., with addresses and phone for each)

Partnership Sole Proprietorship Corporation Limited Liability

Type of Operation: (Circle all that apply)

Parenteral Admixture Retail Limited Service Institutional Provider

Does your pharmacy fill prescriptions for Internet sites? _____ Yes (website: _____) _____ No

Does your pharmacy have contract physicians? _____ Yes (attach listing) _____ No

Resident State: _____ **License #:** _____ **Expiration:** _____

DEA #: _____ **Expiration:** _____

Have any of the applicants had: (If answer is yes to any of the following attach documentation)

Conviction relating to the distribution of drugs, including samples? _____ No _____ Yes

Felony convictions under federal, state or local laws? _____ No _____ Yes

Suspensions or revocation of licensure for the manufacturing or distributing of drugs, including controlled substances, by federal, state or local laws of any license currently or previously held by applicants? _____ No _____ Yes

Have any application for licensure been denied by any federal, state or local agency? _____ No _____ Yes

****If this facility ships controlled substances, has the PIC reviewed and implemented the reporting requirements of Rule 469.01** _____ Yes _____ No

****If this facility does not ship controlled substances, or is an Institutional Provider only, has the PIC attached a letter requesting exemption from reporting?** _____ Yes _____ No

Signature of PIC: _____ **Date:** _____



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PATIENT COMMUNICATION WORKSHEET

Idaho Code

Title 54 Professions, Vocations and Businesses

Chapter 17 Pharmacists

54-1747 PATIENT COMMUNICATION. Every out-of-state mail service pharmacy shall, during its regular hours of operation, **but not less than six (6) days per week, and for a minimum of forty (40) hours per week**, provide a toll-free telephone service to facilitate communication between patients in this state and a pharmacist at the pharmacy who has access to the patient's records. This toll-free number shall be disclosed on a label affixed to each container of drugs dispensed to patients in this state.

AFFIX
LABEL
HERE

*****If 'on-call' hours are indicated, you must include
Policy & Procedures regarding 'on-call' hours*****

Record hours patients may use toll-free number to speak to a pharmacist as per 54-1747 (above); INDICATE if hours are on-call hours.			
Day	Hour beginning	Hour ending	Total # of hours
<u>Monday</u>			
Tuesday			
Wednesday			
Thursday			
<u>Friday</u>			
Saturday			
Sunday			
Total days per week:		Total hours per week:	

SIGNATURE OF PHARMACIST IN CHARGE